Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 9-26-01.

   b. The request was received on 1-24-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. EOB
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. There was no carrier sign sheet noted in the dispute packet. However, the Respondent's initial response is reflected in Exhibit II. All information in the dispute packet will be reviewed and a decision will be written accordingly.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 1-23-02:

   "My position on this dispute is there is no reasonable explanation why these claims should not be paid in full. This procedure is a first time EMG/NCV. The Rule 134.600-H does not apply to this service, therefore, no requiring any pre-authorization…"

2. Respondent: No position statement.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 9-26-02.

2. The Carrier has denied the disputed services as reflected on the EOB as, "A – PRE-AUTHORIZATION NOT OBTAINED".

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
9-26-01 9-26-01 9-26-01 9-26-01	95900 95904 95935 95935-50	$504.00 $240.00 $400.00 $400.00	$-0- $-0- $-0- $-0-	A A A A	$64.00 ea. nerve $64.00 ea. nerve $53.00 #6 max $53.00 #6 max	TWCC Rule 134.600 (h)	The carrier has denied the disputed services as "A". After review of the information submitted by both the Requestor and the Respondent, there was no documentation noted to indicate that these were repeat diagnostic test. Therefore, reimbursement is recommended in the amount of **$596.00**. 9-26-01 95000 x 4 units = $256.00 9-26-01 95904 x 2 units = $128.00 9-26-01 95935 x 2 units = $106.00 9-26-01 95935 (50) 2 units = $106.00
Totals		$1,544.00	$-0-				The Requestor **is** entitled to reimbursement in the amount of **$596.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$596.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 10th day of September 2002.

Lesa Lenart, RN
Medical Dispute Resolution Officer
Medical Review Division

LL/ll